Department of Mental Health (DMH)
Mental Health Services Act (MHSA)
Community Services and Supports Component
Stakeholder Input Process

Workgroup: Sections I-IV of CSS Draft Requirements
March 7, 2005

Meeting Summary
For Discussion Only

I. Background

The Mental Health Services Act (MHSA) became state law on January 1, 2005. The passage of the Mental Health Services Act (MHSA) has created the expectation of a comprehensive planning process within the public mental health system. The multiple components of the Act are designed to support one another leading to a transformed culturally competent mental health system. This concept is embodied in the Department of Mental Health's MHSA vision statement: "DMH intends to assure that county mental health departments expend funds made available through this Act to transform the current mental health system in California and move it from its present state toward a state-of-the-art culturally competent system."

On February 15, 2005, the Department of Mental Health (DMH) released a draft of the Program Plan Requirements for the Mental Health Services Act (MHSA) Community Services and Supports (CSS) component (referred to throughout this summary as "the Draft CSS Requirements"). Broad-based stakeholder input is critical for this document to reflect the goals of the MHSA in transforming the public mental health system beyond "business as usual."

The second workgroup session of the DMH MHSA stakeholder input process on CSS was held on March 7, 2005 in Sacramento. A Client and Family Member Pre-Meeting, held from 9:30 – 11:30 a.m., provided an opportunity for clients and family members to discuss the workgroup session purpose, review the workgroup agenda, ask questions, provide feedback and network with each other. Both the pre-meeting and the workgroup session were introduced with the same basic information and overview. The workgroup was held from 1:00 – 4:00 p.m. Seventy-three (73) individuals attended the Client and Family Member Pre-Meeting and 172 attended the workgroup session. In advance of the workgroup, the agenda for the session was posted on the DMH website with the Draft CSS Requirements. The CSS Requirements Paper was drafted by DMH with the intention of providing a document to which stakeholders could respond as part of the process of developing final requirements for the counties.

This workgroup is the first of three related workgroups to solicit stakeholder feedback on the Draft CSS Requirements. This workgroup meeting covered the first four sections, I – IV, while March 23 will cover Sections V – IX. The March 30 meeting will cover the financing relating to CSS.

The afternoon workgroup session began with a thirty-minute orientation to the process for the day's meeting and for the follow-up meeting on March 23, 2005. Participants self-selected to participate in one of four age-based small groups at the end of the orientation: children and youth, transition age youth (16 – 25 years), adults, and older adults. Each group discussed the same seven questions that were listed on the agenda with comments for their specific group. The order of the March 23 afternoon session will be reversed: it will start with the age-based small groups and then end in one large group meeting with all participants. Participants were requested to attend the same age group meeting at each of the workgroup sessions to provide consistency. An evaluation was completed at the end of the workgroup meeting. Evaluations will be completed at the end of each meeting, with the goal of continuous improvement of the process.

A. Anticipated Outcomes

The outcomes of the workgroup meeting are:

1. To identify areas where CSS Draft Requirements in Sections I-IV are/are not consistent with the intent and purpose of MHSA and DMH's vision statement and guiding principles.

2. To identify areas of the CSS Draft Requirements in Sections I-IV that are unclear or confusing

3. To identify strengths and weaknesses in CSS Draft Requirements in Sections I-IV, with recommendations for improving the document

II. Client and Family Member Pre-Meeting (9:30 – 11:30 am)

Seventy-three (73) people attended the Client and Family Member Pre-Meeting. Simultaneous interpretation was available in American Sign Language (ASL) and Spanish.

A. Pre-Meeting Purpose

Bobbie Wunsch, from Pacific Health Consulting Group and facilitator of the DMH MHSA stakeholder process, described the purpose of the pre-meeting: to ensure that clients and family members (C/FM) attending the workgroup have the opportunity to contribute their knowledge effectively at the workgroup meeting. The pre-meeting was introduced

as an opportunity for general orientation and information. Carol Hood, DMH Deputy Director, introduced DMH staff. Ms. Wunsch introduced the Pacific Health Consulting Group staff.

B. Discussion of Stakeholder Input Process

Ms. Wunsch clarified an issue that has been raised repeatedly: DMH has asked that organizations, providers and counties generally send only one person to workgroup and stakeholder meetings. This is to increase the likelihood that work can be accomplished during the meetings. DMH encourages as many clients and family members as are able to attend any workgroup meeting that interests them. DMH encourages participants to invite other clients and family members, especially parents of children or parents of adults to participate. These voices are essential to the process. Other ways to provide input are encouraged as well, using email, the telephone or U.S. mail:

1. Email mhsa@dmh.ca.gov. All emails go to the MHSA Team at the Department of Mental Health. The team will answer the questions in a timely manner.
2. Call the toll free number: 1-800-972-6472 (MHSA). MHSA team members will respond to calls within five working days.
3. Write to: Carol Hood, Deputy Director
   Department of Mental Health
   1600 Ninth Street
   Sacramento, CA 95814

The summary from the first workgroup, cultural competence, is posted on the website, www.dmh.cahwnet.gov/MHSA/.

Q. Is there an access number to get into the conference call?
A. There is an 800 number, which is on the cover page of the PowerPoint presentation for each of the conference calls. There is no password. There may be a small delay for getting onto the conference call, because so many people are calling at once.

C/FM Comment: It makes clients and family members distrustful to have to provide their names to participate in the conference calls and to signal to ask questions during them. Some just want to listen and learn. There is a level of distrust already. Clients and family members perceive that there is a screening process, with a pre-approved list, preventing participation on a whim, or requiring planning that may not be appropriate for some clients. There is concern about where the lists of names will appear. DMH should consider engaging a consultant who has had bad experiences with the mental health system in order to have systems in place that will better reflect sensitivity to client culture.

DMH Response: This is a good point. We do not need to ask people's names to join the call. However, in order to organize input from 300 people on the call, we do need an orderly way for people to signal when they have comments or questions.

Q. Why is the financing workgroup not part of this continuum? The financing follows the money, it should be related? It should be the same people.
A. This is a good point. We will encourage participants to attend all three workgroup meetings and will look at them as a series.

C/FM Comment: This process is not oriented to clients and family members. Ask people to come to the next meeting with two programs. For example, what if the county has different plans: one based on the Villages model and a program to award associate degrees for consumer peer counselors at the local junior college? These do not seem to fit into the plan requirements. This is the perfect example of bureaucratizing a good idea. Use block grants for the first year. Go back to the drawing board and be less prescriptive.

DMH Response: DMH is trying to develop a statewide approach to assure that the county planning process would have depth and would be comprehensive and inclusive. DMH is mindful that when this process is over, the Department will need to tell the voters of California that their money was spent effectively, through a unified story.

C/FM Comment: Nonetheless, this document makes it appear that DMH is artificially fragmenting programs. Try doing it another way.

DMH Response: Staff will do its best to have examples of how different programs might fit into the draft requirements at the March 23 meeting.

C/FM Comment: The meeting dates fluctuate all over the days of the week.

DMH Response: DMH has attempted to spread the days across the week to provide the opportunity for as many people as possible to participate. Unfortunately, the workgroup sessions are also in different locations. The day of the week, the date and location will be posted on the website. If you do not have access to the web, let people at the registration table know and DMH will mail you the materials.

C/FM Comment: These pre-meetings would be better if they had a large component during which clients and family members could just talk about issues together.

As a result of this comment, Ms. Wunsch requested a show of hands of who wanted this use of time. Many people expressed support. While one person recommended that C/FM use lunchtime for such purposes, most people expressed an interest in using some of the pre-meeting for that purpose. As a result, Sharon Kuehn, a C/FM and provider, took over facilitation of the pre-meeting. People lined up at microphones, while a roving microphone was brought to people with mobility issues. Below are comments that were made by C/FM during this self-facilitated session, organized by topic.

Enrollment Issues

- Can someone please explain the reason for using enrollment?
- There is no way clients are going to get enrolled or assessed; they barely trust the peer providers.
- The enrollment component comes from AB 2034, which started as AB 34. Currently, 32 counties and two cities have it. For those counties that do not have an AB 2034, think of it like joining the local YMCA.
- Enrollment would be a discouragement for those who are hard to serve; it is unimaginable that clients who get no services at all, live in remote areas, or have been provided poor services would be willing to be enrolled.
- Enrollment should not be an obligation.
- With AB 2034, clients do not enroll until months into the process.
    - **DMH Response:** Right now, AB 2034 is limited: it has a cap on number of potential enrollees.
- Can someone from the State give a justification for enrollment?
    - **DMH Response:** Prop. 63 was built on the Children's System of Care and AB 2034, which both include enrollment. It expresses a commitment on the part of the county to do whatever is necessary to serve the client, as opposed to what many of you seem to be hearing as a requirement for the client. As a part of it, the client and family and CMHS jointly develop an individualized treatment plan. This model can transform the system through the enrollment process.
- DMH sounds as though they are saying that counties have an open budget. But counties do not meet all the needs of those already identified.
    - **DMH Response:** We are trying to start providing care the way we think it ought to be with a core group of people. That means that other people will not have the new, higher level of service Enrollment was not meant to be an obligation, but a commitment from the county, to provide service based on a mutually agreed upon plan.
- It assumes that people know how to make those plans or will want them.
- How will clients and family members know that services will be how they want them?
- The concept of "whatever it takes" has more to do with the underlying concept rather than enrollment. However it was a little more restrictive than enhancing services.

Client-Driven/Directed Programs and Philosophy

- It seems like peer programs are involved on the margins, not in the center. Clients and family members want to create a revolution in the bureaucracy.
- Client-run services are completely missing in the data collection component and they are critical; the services we need and want have to come from us.
- There is not enough about client-directed care.
- People in focus groups generally do not know what client plans are. At the county level, folks should go to self-help groups and networks, to learn about the treatment plans and how to control their own.
- The people without degrees should have a measurement tool to identify whether people are making significant progress.

- DMH appears to also want a language shift, but it is not clear that it will it be sufficient.
- Why not give clients $5,000 to figure out how to best spend the money?
- Love is an evidence-based practice.
- Page 4, 3rd bullet: consumer and family-driven system. Insert this throughout the document. Stop arguing about language and let's get to the meat of our problems.
- Language is very important, but there needs to be dignity and respect behind those words.
- We do not need this disenfranchised language. Love is really important.
- Page 24: clients and family members should be part of the people part of the 24/7 response team.

Cultural and Age Competence

- I hate wearing things around my neck, and yet I know wearing name tags helps the meeting. I had a therapist who gave self-care. I'm now off the streets and a therapist. But it will not work for everyone. The plan needs cultural competence. What's here is inadequate. It must include competence in serving all genders, gays, lesbians, bisexuals and transgender people. It should also include religion and spirituality.
- Ensure that counties pay particular attention to ethnic disparities in all four age categories, including people with physical, developmental, hearing, vision, cognitive, learning and/or other disabilities; gay, lesbian, bisexual, transgender and questioning people; and survivors of sexual assault and domestic violence.
- There has not been mention about children here. Treatment plan issues are similar: parents often do not know what's in their child's plan. Therapists do not tell parents. Children need an integrated plan as well as adults. It is important to work together in both systems to treat the family as a whole, not separately.
- This has been a very technical meeting, which will not help foster kids prepare to share at the workgroup meeting. Foster kids do not have the support that others do. It would be important to outreach to them, possibly having a special pre-meeting for children and youth.
- There needs to be some kind of prescription about who the outreach workers are and how they are trained in terms of cultural competence. They should be able to have one-on-one contact to meet people where they are. For example, use reservations and community centers to reach Native Americans. Get a sense of how welcome you are and if you are not, then leave. If we do not do the footwork, we're not going to reach the people.
- The tribal people are not served by anyone. This document talks about rules and regulations. There are many letters going into the state about this. It never helps. Tribal people do not hear about any of this. Discrimination is still rampaging, racism is all over, on our boards, in the counties. No one cares. If you address the question, you have to be willing to look into yourself.
- How loose is the state going to be in letting other plans come in? Tribal groups will submit plans to the state directly for MHSA funds.
- A lot of Native Americans on reservations do not know what is available for them. Casinos have not raised all tribal people out of poverty. Counties need to look at all its people in need, not just those who show up.

- People in one county are forming a coalition of people who are not served: Spanish speakers, uninsured, not served, low-income, Native Americans. This coalition will submit a plan to the state in a set time and wants support from the Network.
- Racism against Native Americans is a huge challenge for the white community. Is it possible, despite the history for Native Americans and the white community to work together in counties? Some are trying to support the communities doing their own self-directed work to work together. Is there a way to do this together, even across these ethnic lines?
- No communication is being put out to Native Americans. If you want those voices, provide resources to come to the meetings.
- Page 15: General requirements for all populations: add language throughout the section. The racial consciousness of mainstream providers needs to be widened. For instance, the county could hire a Chinese coordinator who may speak one dialect but not be able to serve the Vietnamese, Korean, Cambodian populations. The issue is to be able to provide appropriate language access and have skills in the topical area (social work); it is not satisfactory to rely on a phone bank translation or family member to translate which is often done currently.
- Page 16: add onsite services in primary care clinics with primary language accessible services.

Client and Family Member Participation Barriers and Solutions

- Many clients do not have the resources (network, funding, knowledge) to get to these meetings. Use some of the MHSA money to bring clients and family members in a day early and bring as many as possible.
- This is about what will happen at counties. Counties need to provide food, transportation, etc. to get consumers to the meetings. Consumers are crucial to the brainstorming part.
- Clients and family members need to do something not just at lunch, and need a break, down time, in between the two meetings. When materials have been requested by U.S. mail, they have not been provided. If we're going to work together, we need to dial down the hostility.
- Consumers are being asked to participate in focus groups without training. The intention is good, but counties must obtain training in how to work with clients and family members.
- Many clients and family members are feeling rushed and pressured and feeling a need to respond. Having a day together, before the meeting would be great.
- This process feels so totally controlled. By contrast, the Consumers' Network meeting was so good. We need to be able to get together to hold onto our dreams.
- There need to be more people at the table and people need a time to regroup.
- Maybe the Client Network could have a conference call before the conference call and agenda are set up.

CSS Draft Requirements Concerns

- In Section II, the outcome "Community Issues resulting from Untreated Mental Illness" measures only address objective criteria but should include subjective experiences of empowerment, independent living, social connection, and quality of

life. Add individual issues as a distinct category in Section II, such as *"Identifying Individual Issues resulting from Untreated Mental Illness,"* as well as subjective individual outcomes, like those found in the literature that addresses empowerment, independent living, social connection, and quality of life. (e.g., Steve Segal: "Personal Empowerment Scale" indicating a person's control over different functions in life; Judi Chamberlin, Project Director at the Center for Psychiatric Rehabilitation, Boston University; and Jean Campbell, Program in Consumer Studies and Training, Mental Health Services Research Division of the Missouri Institute of Mental Health).

- Using individual outcomes in Section II may change responses to Sections III and IV, with possible additional priority focal populations such as
  - People currently institutionalized or in board and care homes;
  - People getting minimal services, such as periodic medication visits only, that is, anyone not getting the full array of psycho-social rehabilitative services.
- Section II about the unserved is fine, but Section III about the underserved is not clear. 80% of clients and family members currently served would not fit into these categories. Section IV identifies the two groups and then prescribes responding with low staff caseloads. Counties should be allowed to take the results of successful programs to address unmet need?
- In Section II, change language to Identifying Community Issues resulting from *Lack of Community Services and Support.*
- Wellness and recovery types of approaches are lacking. While the words are there, they are not in the programs and services.
- In Section III, add self-help and client-run services to the list of "service category groupings." Otherwise, self-help and client-run services are omitted as a current service category.
- In Section III, counties should respond to utilization of peer support services in each type of treatment category: inpatient, crisis, outpatient, and day treatment/residential.
- AB 2034 is not an evidence-based practice, and the entire Mental Health Services Act is based on it.
- The Network has a MHSA Client Implementation Team which put together some concepts about the draft requirements. While the logic model is excellent, it requires that you start with the right objectives. This document does not identify individual issues, does not look at empowerment, social connections, quality of life. If it did, it might allow for some different priorities in a county's focal populations to emerge – like board and care residents, or clients who are only getting medication appointments every six weeks. That could only happen if the outcomes include these individual objectives and measures.
- Under "Essential Elements for All Three-Year Program and Expenditure Plans" "Wellness Focus":
  - The description of total recovery, which is portrayed as achievable in the President's New Freedom Commission" as "complete *remission*" is clinically based and misunderstands the whole concept of recovery.
- The New Freedom Commission does not use the word "remission."
- In Section IV, the language about who is considered underserved and unserved should be respectful. For example, change "SED: to "have been diagnosed with…" Use language that clients are comfortable with.

- The requirements as written are not going to save people who need services.
- Substance abuse is not addressed appropriately; how can we enhance this? Almost everyone with serious mental illness has other health issues and needs integrated services.

Timeline Issues

- This process is going at a juggernaut speed. DMH is coming to conclusions very quickly, when this should be done carefully. DMH is not modeling for the counties.
- Clients and family members are not clear why the process is so sped up. To achieve system transformation, the process must go slowly and thoughtfully.
    - **DMH Response:** There are some who say, "Why don't you get a move on? Get the money out there, there are people who need services." There are others who want us to slow down. DMH needs to find that balance between deliberation and moving forward. The money will start to build up in the coffers very quickly and will become vulnerable. There is already a law suit and an initiative to repeal the law. DMH needs to be able to show some outcomes early. Stakeholders should look at this not as a one time only opportunity, but as there for the long haul. Not everything will be done perfectly. DMH staff are trying to keep up with the county planning processes, many of which are underway already. They need to know what they are planning for.
- The part of the proposal about identifying the underserved, at risk, etc. sounds like, "everyone who is not here, stand up." How can counties do a good job in the time and with the limited resources provided? Counties know who the squeaky wheels are, but not who the quiet people are. Counties need to do a good job finding those people and do a better job serving those already served. All that specificity tends to pull focus away from the big picture, of what MHSA is really trying to do.
    - **DMH Response:** Right now, DMH is not proposing a deadline on the county plans, so that counties can take as long as they need. Counties can submit their plans when they are ready and the money will be there. DMH knows the system to date has only served a small proportion of those in need.
- While people on the streets do need services now, do not rush through the process. You need a revolution in these services.

Client and Family Member Networking

- DMH should formally support the client and family member process. It's all moving forward quickly. Clients and family members have not had time to get together.
- Clients and family members need to have a space to start to think about statewide client networking. This process is not taking care of it. Clients are not being included. For example, the California Network or NAMI could help raise the issue of absence of crucial personal measures of satisfaction in the document and then clients and family members need to talk about it as a group and have time to respond.
    - **DMH Response:** Part of your role as client and family member participants is to bring information back to your communities.

Training Issues

- There is a state plan for training, on such things as AB 2034, Children's System of Care (CSOC), etc. If a county does not have those programs, the county will need training. The counties are asked to do their own training, but there is no systematic approach to who will do the training and what their qualifications should be.
- Until one has participated in training, even the questions to ask are a mystery.
  - **DMH Response:** There has been some training done on teleconferencing. However, the quality was so poor, it needed to be redone. The new improved version is about to be widely distributed, with Darryl Steinberg and others. We are preparing to put a system in place. However, the training and education component is later on the MHSA agenda for long term planning, so we need an interim plan.

III. Workgroup on Sections I – IV of CSS Draft Requirements (1:00 – 4:00 p.m.)

One hundred seventy-two (172) stakeholders participated in the workgroup session on Community Services and Supports (CSS) feedback on Sections I – IV of the CSS Draft Plan Requirements, on March 7 2005, from 1:00 – 4:00 p.m. Carol Hood, DMH Deputy Director, thanked everyone for coming.

A. Purpose of Meeting and Organizational Structure of Workgroup Process

1. Purpose and Process

Bobbie Wunsch, Pacific Health Consulting Group and facilitator of the MHSA stakeholder process, explained the purpose of today's meeting and the organizational structure of the workgroup process, and, specifically, the structure of the three linked meetings. This is the second workgroup session for CSS, and the first of three related workgroups to solicit stakeholder feedback on the Draft CSS Requirements to strengthen and improve the draft document and make it more effective. Today's meeting covered the first four sections, I – IV. March 23 will cover Sections V – IX. March 30 will cover the financing relating to CSS. The summary of the first workgroup session, which addressed cultural competence, is available on the DMH website.

Other upcoming important workgroup dates include a conference call on March 14, from 3 – 4 p.m. on Sections V – IX and two concurrent workgroups on March 16, one to solicit input about challenges to small counties and the other on short term strategies. There will be general stakeholder meetings on April 5 in Los Angeles and April 6 in Sacramento. The meetings on April 5 and 6 are duplicative; participants are requested to come to only one. One combined summary will be written for each pair of stakeholder meetings.

2. Participation

Clients and family members are encouraged to attend any workgroup that interests them, while agencies, providers and counties are encouraged to send only one representative to each session, in order to maximize diversity in workgroups, but keep them manageable in size to allow the opportunity to get work done. Stakeholders who choose not to attend a workgroup, but want to stay abreast of the process, can read the summaries of meetings which are posted a week after each meeting. In addition, feedback on draft documents in writing, either by email or U.S. mail, and by telephone is also being solicited. The deadline for feedback to the Draft CSS Requirements document is April 1, so that the document can be revised by May 1.

3. Questions and Comments about the Process from Participants

Q. Why did DMH release a document without client and family member input?
A. The document was written with the intent of providing stakeholders something in writing to respond to. Four clients and family members participated in the team who drafted the requirements. After feedback is obtained, staff will rewrite it. The Department is taking the stakeholder process very seriously and wants to improve the document, finalizing it by May 1.

Q. What is the difference between children's and transition age group meetings?
A. Children and youth can also include transition age youth. MHSA has a particular focus on transition age youth (16 – 25), for the transition issues. The group is not limited only to foster youth and youth in the juvenile justice system.

Q. Is the state asking for a three year plan or a one year plan? Please clarify.
A. We want the plan to cover three years, but with more specificity for the first year.

Q. Will we be able to revise the three year plan after the first year?
A. Yes. The chance we have to transform the system relies on everyone thinking of this process as a developmental, ongoing one.

Q. My daughter will be on vacation in two weeks for five weeks and so I can't continue to attend these meetings. What am I do to?
A. There have been many legitimate requests for such items as child care. We cannot meet them all. We are providing resources so that each of the statewide client and family member advocacy groups can send representatives. People are welcome to bring their children to meetings if they need to.

Comment: The request for childcare has not been responded to adequately: we can do better. If DMH is unable do it, at least encourage the counties to provide it, or provide it on site.

Comment: I see an overall theme for this process: Educate, motivate, legislate and activate.

B. Small Group Discussions

The workgroup divided into four smaller discussion groups based on age groups, to provide specific input on Sections I – IV of the CSS Draft Requirements: children and youth, transition age youth (16 – 25), adults and older adults. Each of the small groups discussed the questions identified on the agenda. The feedback is separated by age group.

1. What key issues and outcomes consistent with system transformation and the MHSA are missing?

Children and Youth

Outcomes

- The outcomes listed are very broad. What kind of criteria will the state use to determine, what is, for example, a "meaningful use of time and capabilities?"
  - **DMH Response:** These outcomes are broad. Appendix B (Performance Measurement) gives more detail.
- The work on outcomes for children has a long way to go. They should be broken down: for example – children with specific diagnoses.
- Use standards from Children's System of Care, such as reduction in out-of-home placement, juvenile justice involvement, hospitalization, etc.
- Use outcomes from First 5 for the very young, birth to 5, including measures of attachment and school readiness.

General Issues

- Break down by population, with a section for each age population.
- Improve access to services in crises, with help coming to clients and families in their homes and communities, not traumatizing them further.
- Address early intervention.
- Add early identification.
- Add child's functioning in the family.
- There needs to be a much broader definition of identifying needs.
- Contextual issues are insufficiently addressed; for example, poverty, neighborhood violence, and disparities in access to mental health services all contribute to juvenile justice involvement.
- The document contains no language specifically addressing cultural and linguistic barriers.

School Issues

- Programs need to implemented in schools, which is where many of children's problems occur and where there are huge gaps in services and supports.
- Educational performance should be an outcome measure.
- Offer counselors in schools before mental health becomes a problem.
- Intervene in families with multi-generational mental health issues.
- Track suspension and expulsion data from schools.

Technical/Data Issues

- Counties have already started their planning processes. Designing appropriate community surveys and getting information back takes time. How does that fit with the fact that DMH is pulling this together after planning has already started?
- There is insufficient policy guidance from DMH about accuracy in documentation regarding outcomes; this is a place that DMH should be much more directive to counties.
- Issues should be data-driven.
- Page 10: Direction, first sentence: it sounds like counties would just pick one thing to work on – or is that not the case?
    - **DMH Response:** That is up to counties. There is no prohibition to do only one. This is taken from the Act. Counties can make a case for something that is not in here (i.e. multiple issues/multiple populations). DMH encourages small and smart, and not to get spread too thin. For the beginning, keep it narrow and add to that over time.
- Change "Children" to "Children/Youth" everywhere.

Transition Age Youth (16 – 25 years)

General Issues

- Page 2: in describing "meaningful use of time and capabilities", it would be useful to add specific examples for the transitional age youth, e.g. in school, vocational training. There needs clarification of what "meaningful use of time" means for transitional age youth.
- There should be a requirement for ongoing assessment as to whether services are available and accessible to transition age youth in the *"Essential Elements for All Three Year Program and Expenditure Plans*" section.
- Assessment tools should include measures of the impact of the services and whether the services make youth feel better.
- The guidelines should include legal assurances that clients who are 18 years and older have access to services and programs.
- Add training for youth service providers.
- Add funding for implementation of youth services and advocacy.

Outcomes

- Regarding outcomes, DMH should be explicit about how success is defined.
- The outcomes measurements should include empowerment, quality of life, social connectedness, self-sufficiency, and independent living.

- Additional outcomes specific to employment for youth might include:
  - Supportive vocational education programs;
  - Internships for youth in mental health services;
  - Workforce Investment Act (WIA) funding for employment assistance;
  - Partnerships with State Department of Labor;
  - Ongoing employment.
- Broaden the education outcomes to include higher education.
- Consider outcomes specific to the rates of suicide.
- Outcomes should include tracking consistency and quality of services specific to transition age youth.
- Add outcomes specific to client-run, self-help and peer support programs and services.

Adults

General Issues

- Counties need a clear indication of the state's expectations: which are counties required to be held accountable to; which can we let go of?
- Page 2: add a disclaimer paragraph describing how prescriptive the DMH will be, such as "This is a developmental process, we have outlined one way, other ways are acceptable."
- Line staff should be involved in the planning process among counties.
- This document is the foundation by which this system will be based for many years. Slow down and get it right.
- It would be good to have a second review period after this document is revised.
- The document must be clear and concise, so that anyone can understand.
- There should be a full glossary where terms are clearly defined so anyone reading it has the same understanding.
- It would be appropriate to have a meeting or two for clients who want to have input about outcomes.

Specific Issues

- We are looking for something different from the state: technology and accountability.
- There needs to be discussion in the document about Post Traumatic Stress Disorder (PTSD), which is the missing component in treatment in CMHS. It is the largest unmet need.
- PTSD can be a killer: Vietnam vets have self-medicated and are now dead.
- Page 2, third paragraph, fourth bullet: "access to help in a crisis" is not exactly right; it should be "access to help whenever it is needed."
- Add "Board and Care" wherever it says "underserved."
- There is no language about harm reduction.
- Talk about the money going to the client which the client can decide how to spend, as well as about scholarship systems.
- Section III: include a flexible fund account for uninsured; many people fall into this category.

- Permanent housing is missing.
- Add importance of hiring consumers.
- There should be an overall strategy of looking at less restrictive, lower levels of service, more recovery based: move from a “fail first” to a “help first” orientation

Training

- Counties should have a solid plan of where their training is going: where they want to move their whole system, with a plan of how to get there, including training.
- We need to train therapists on wellness and recovery models, not just the planning process.
- We’re acting as if there is a cadre of people who understand the model and can provide the training, but that’s not the case. The model and clear orientation does not exist yet. It’s not about money; it’s about orientation and who is available to provide the appropriate training?
- DMH needs to be more prescriptive about training: we need people who know what they’re doing.
- Training is supposed to be included in the “plan the plan” process.
- Training needs to be more explicit and specific with a full description, to put the appropriate emphasis on it: types, hours, clients involved.
- Section I, Part 1, Number 4: type and amount of training: Please be more specific about whom you expect us to train and on what exactly. Orientation seems to be a more correct terminology. For example, a one to two hour community meeting that includes a feedback or input time is not a training, it’s orientation.
- The counties need to know how much funding for training and education will be available in the first three years.
    - **DMH Response:** It is not defined at this point. The intention is to go beyond what exists now, to retrain existing staff.

Client-Centered and Wellness Language and Focus

- Page 15: how will the counties get from where they are now to where they need to be to shape services around clients’ needs? Be very clear about what client-centered means and make sure that the language of a client-centered approach is emphasized throughout the document.
- Language is very important: on page 4, add “client-centered.”
- Page 4, last bullet and Page 16, first paragraph contradict themselves in terms of what “client-centered care” means: first it says “consumers identify their needs and preferences, which lead to the programs and provider that will help them most. Their needs and preferences drive the policy and financing decisions that affect them.” Later it says, “each enrolled member will partner with the county mental health program to develop an individualized service and support plan.”
- What is a “”full partner”? What is “meaningful involvement” for clients and family members? Have the clients and family members figure out what to do and then bring the providers back in.
- There are a lot of specific recovery strategies. An overall structural plan for the county to become more supportive of wellness is missing.

- The whole area of personal empowerment and recovery, by the people themselves, is missing, including quality of life, independent living, social connections; the emphasis on empowerment needs to be included throughout the document
- Where are the “teeth” behind “client-directed” in the requirements?

Outcomes

- Look to L.A. for client-centered outcome measures, including: client feels s/he lives in a safe and friendly environment; has friends and family; has access to help in a crisis and to weather a crisis; has access to physical health.
- Reduction in institutionalization as an outcome.
- Alternatives to institutionalization should be included.
- Access to prescriptions wherever clients go.
- Need client reports on services received.
- Page 2. Outcomes: add people who live independently.
- Page 2. Outcomes: is this the individual’s perception of the outcomes or the system’s? Are we providing an array of choices?
- There need to be outcomes for systems transformation and for consumer and family/support groups. Each of the community-based organizations (CBOs) within the county should have an advisory committee of client and family member support groups. Some will want to have them separate and some together. They will ask how the county has responded to the client and family member support groups. With this method, priorities for funding will be bottom up rather than top down.
- Outcomes should be on different levels, starting with clients, then system accountability, then community.
- Who makes up the criteria about outcomes? Are clients involved?
    - **DMH Response:** DMH intends to take a leadership role, with multiple stakeholder input, to arrive at client outcome measures that are uniform across counties, meaningful, and feasible to collect. In order to inform this process, DMH summarized outcome concepts stipulated in Realignment Legislation and other statutes (e.g., AB2034) that were previously derived from stakeholder processes. The result was a set of core outcome concepts that stakeholders (e.g., providers, clients and families, measurement experts, administrators, etc) will now be building upon, refining and modernizing with respect to transformational recovery and resiliency philosophies pertinent to MHSA intent. Specifics for indicators and reporting will be standardized across counties so that a statewide story about effectiveness of the MHSA may we told. Counties will be expected to collect and report data in the uniform way that will be determined. This does not preclude counties from capturing additional data for their own purposes with respect to the populations that they serve.
- It may be okay to let a county identify their outcomes. If we do not put a dollar value, we cannot determine how effective the work is.

Cultural Competence

- By and large, a lot of Asian clients and family members want trusted advocates to speak up for them. They will not do it themselves. They will not get their needs met unless they go to the line staff.
- There are not as many people from different cultures here as came to the last meeting: their input is important. If they were paid to come, that would help.

Older Adults

Service Integration

- Must address both physical and mental health needs, treatment and follow-up; physicians often do not understand mental health issues.
- Need to integrate medical care and mental health, especially because medical issues become more important as a person ages.
- Community Care Licensing does not acknowledge medical issues for older adults.
- Using an integrated and comprehensive approach is a necessity: How do we get there?

Dementia

- Where is dementia? We need a broad definition that fits with mental health services
- How should dementia be addressed?
- Dementia requires flexibility in mental health necessity guidelines.
- Dementia is a huge issue for older adults. We must be able to respond to it.

Medications

- Medication is a huge issue for older adults.
- What will be the impact of Medicare drug benefits on MHSA and Medi-Cal benefits?
- Doctors do not consider interactions of medications prescribed by other providers.

Comprehensive Health Assessments

- Older adults are not assessed on an ongoing basis; changes need to be noted and clients need comprehensive assessments.
- Staff need training to assess multiple issues, using a tool like the Geriatric Field Screening Protocol.

Other

- Residential programs specifically for older adults are needed.
- Incorporate recovery values for older adults.

2. Are the format, approach and language used in the document consistent with the message of system transformation, and the concepts of a culturally competent consumer and family driven wellness oriented system? If not, give specific examples of what would be better.

Children and Youth

Lack of Emphasis on Children/System of Care

- Overall, the document does injustice to children: it needs to speak more specifically about children's issues separate from adults, with language more appropriate to their issues.
- Disability prevention: early diagnosis and treatment are needed to reduce disability. Children are not included.
- Address how to work this magic in the absence of the System of Care function, as some counties have neither System of Care nor Wraparound; not all children and youth will be served by MHSA; then what?
- Page 5 language is inadequate for children. Use language in System of Care.
- "Recovery" is adult language; "full inclusion" is more pertinent for children who do not recover in the same way. Goal is to keep children included in community.

Client and Family-Centered Focus

- Add consumer and family-driven.
- Address need for parent education.
- Do not lump all youth age groups together: children cannot be treated outside of family, in contrast to transition age youth, who may be independent.
- Strengthen "family" rather than just children – add "with their family."

Schools

- Make mental/emotional well-being a part of the state education curriculum.
- Add that schools can be an access point for identifying needs.
  - **DMH Response:** We are looking for system capacity strategies. There is nothing to direct a county to identify access points. This can be part of structural, service, and support strategies for community-based services.
- Include schools as a wellness prospect for children. Grade advancement is never well-addressed: poor graduation results. Address wellness in relation to performance and success in school.

Cultural and Age Competence

- Add a column for ethnicity on the charts on Pages 11 and 13.
- Language regarding issues of access and disparities needs to be repeated throughout the individual sections, not just in Cultural Competence section; the Cultural Competence document should actually be embedded in the guidelines rather than set apart as a separate document.
- Include self-esteem and socialization. Children may not be identified as having a problem, but when they work with other children, problems may become apparent.

Other

- The document asks how counties outreach, but does not require a summary of what was learned from outreach and how it is reflected in their plans.
- Require that counties list the issue and the resulting problems.
- Advocacy groups do not always represent children's particular needs.
- Add community based health care needs.
- Stigma and awareness. Not seeking help.

Transition Age Youth

General Issues

- Overall, the language appeals to and is understandable by county administrators. The document needs to be more understandable to different stakeholders and include the youth voice, which is missing in the document.
- MHSA/CCS is not accommodating to transition age youth.
- The cultural competence language needs to be expanded to include gay, lesbian, bisexual, transgender and questioning people.
- Page 5: In the *Essential Elements section, the* focus on wellness needs to include youth-relevant concepts and language regarding recovery and resilience.
- In considering a whole new way of doing business, what are the tools and support that transitional age youth need to have a successful life?

Outreach

- There needs to be a one-stop resource center or service center specifically available for transition age youth that is age-appropriate and addresses their needs.
- Section I needs guidance for how to reach out to transition age youth and to ensure that there are more foster youth involved in the planning process.
- MHSA community information should include gathering information from the juvenile justice, child welfare services and school districts.

Adults

Cultural Competence

- Incorporate the feedback provided at the cultural competence workgroup.
- This section does reflect competence regarding "client culture." If it were better understood, the notion and language of "enrollment" would have been eliminated.
- We need to have clients of diverse backgrounds at these meetings.

Outcomes

- Reduce imprisonment of mental health clients.
- Reduce deaths of mental health clients on the street.
- Reduce violence against mental health clients.

Other

- If we were moving toward that ideal system, we would be looking at self-help and client-directed services; none of these services are evident in the service data counties must report (page 12).
- This is systems change, not transformation.
- Develop a better definition about range of housing options.
- House mental health clients first, then deal with the rest of their needs.
- Provide access numbers to call that answer quickly and provide real help.
- Define terms better.
- Include “people who are treated badly” with “untreated.”
- Give more guidance, using language like the counties ”will” rather than “should” identify
- If you do not have the mental health background, there is so much you might not understand in this document: it needs a glossary.

Older Adults

Cultural Competence

- There is a large number of older adults who are gay, lesbian, bisexual and transgender.
- Services to older adults must be provided within their cultural context.
- Hire older adult consumers to relate to older adults.
- Provide direct outreach and education to older adults in Latino and Asian communities, understanding their cultural needs.
- Create flexibility in staffing to hire people who understand cultural beliefs.
- Have forms available in many languages and in large print size.
- Create a reporting system to ensure primary language of client is matched by provider with cultural and linguistic competence and mental health skills.
- Primary care clinics and providers are an important part of reaching and providing integrated services to older adults.
- Use flexible admission criteria, taking into account ethnicity and cultural issues about confidentiality and family bonds.
- Be careful concerning those who speak a language but do not know the culture.
- Printed materials are not always helpful.
- Do not use children or family members to interpret.

Other Issues

- We see ourselves as non-licensed professionals, not para professionals.
- What about developmentally disabled with mental health issues? Should this be added to the plan?
- Need stabilization outcomes for older adults; where do they want to be, choices, outcomes-based wellness and recovery.

- Important to acknowledge that stabilization, rather than recovery, might be an effective outcome for an older adults.

3. Is the document clear about the two types of funding and what the concepts of "enrolled members" and "system capacity" mean for each age group? Is there agreement about the necessity for these two types of funding?

Children and Youth

Enrollment

- What do "enrolled members" mean: what are the criteria?
- Enrolled member represents a case management type program. This would limit integration of community providers, who would need to be connected with the patient who is enrolled.
- Stigma connected to being enrolled in mental health program needs to be addressed. In children, there is no process specified for enrolling and tracking the process.
- Help children to not become part of the system of adult mental health.
- Children's System of Care should be the model; why is DMH not including it?
- Why should one family be enrolled because they enter the system after MHSA is implemented, and another, with a child already in the system, not be able to participate?

Other

- The document uses only adult examples and is not child-sensitive.
- What is the model on the children's side? Language should be inserted.
- What is the time period that counties need to commit to families and their children?
- Define "most" in the phrase "Most of the money."
- Some would want a capitated program, but need to be clear.
- Many programs are needed for children currently in the system. This would bifurcate the system. What percent of current children would be included in each group?
- In referencing children and youth, it appears this plan does not include Medi-Cal beneficiaries; what is the state's intention?
  - **DMH Response:** This is a direct result of the Act, in which the language refers to services for non-Medi-Cal eligible youth.
- Use bold paragraph headings to clarify topics.

Transition Age Youth

- Be more specific about what each of the funding types applies to. Add examples to make this section clearer. The instructions/guidelines must be clear about how a person currently using mental health services is eligible for services under MHSA.

- Regarding the enrollment funding, the description says that the enrollment funding will relate directly to individual consumers and will use the type of enrollment models established for persons served under AB2034. Provide clarity and examples about what this means for people served under MHSA.
- Provide clarity about where most of the money for enrolled member services will be directed. Will the funding be available for self-help services and peer support programs?
- Concern was voiced that the description of member enrollment suggests participation in MHSA is involuntary. Diffuse the sense of forced requirements. Consider describing the participants as volunteer participants rather than enrollees
- Page 6: Provide more clarity about what is meant by the statement: "*these funds shall not be used to supplant existing state or county funds utilized to provide mental health services.*
- Need clarification and examples specific to transforming the service delivery system and building system capacity. Does this include client-operated/client-run programs and services?

Adults

- Is it possible to get rid of the word enrollment?
  - **DMH Response:** We are open at this point to make changes. The word came out of AB 2034, where we considered everyone an enrolled member, as a result of persistent outreach, offering of help and meeting of needs. It was used here, not because an individual would be obligated, but rather to convey that counties would be held responsible for providing the full range of services and reporting outcomes.
- Clients in self-help programs do not want to report to the county; they do not trust the counties. It will not work. Focus on self-help and also do something about getting people to trust you.
- Persistent non-threatening outreach is missing in the document. People have a Hobson's choice: fill out the documents or do not get services. Is there some way to track these people for reporting without requiring them to enroll?
- Peer counselors listen to people, but are called flaky because they do not report outcomes as clinicians do.
- We are not hearing from the medical health directors; we want to hear their feedback so that we can respond to them.
- Mental health directors want to include workers and clients and family members.
- The community mental health agencies who participated in drafting MHSA wanted language to hold counties accountable for the services provided.

Older Adults

Enrollment

- Change the word enrollment.

- Enrollment programs, by nature, will be high cost programs and services.
- Once enrolled, does one graduate or disenroll and then re-enroll if necessary?
- Once enrolled, how does enrollment relate to Social Security benefits and Medicare?

System Capacity and Systems

- Current system does not work.
- Demand for older adult services may be greater than capacity of the system.
- How can we take care of those currently in the system who are not being well-served?
- Considering that there will be two separate systems for clients: the current one is inadequate, and is the medical model with Medi-Cal dominating; and the new enrollment system may be more integrated and comprehensive.
- There is disjointed planning across systems.
- Need systems capacity to offer integrated services to people.

Medi-Cal Issues

- How will the Medi-Cal funding stream change?
- Avoid Medi-Cal language.

Client-Centered Language

- There is a need to change attitudes and system approach with wellness and recovery values and language.
- How can we change the CSS Draft Requirements document to focus more on wellness and recovery, including staff training in resilience?
- Infuse document with language of clients and family members.
- “Remission” is a trigger word that is not positive.
- Change language to use words that are supportive and meaningful, incorporating love, respect and hope, not bureaucratic jargon.

Other

- What will happen to innovation?
- We need to emphasize better communication with clients.
- Stay away from formulas for enrollment and systems capacity.
- A glossary is essential.
- Develop programs in communities that are accessible to and easy to reach for seniors where they live and congregate.
- Different levels of care for individuals are necessary to achieve “whatever it takes.”
- Good concept and needs outcomes evaluation.
- General consensus in group that concepts of enrollment and systems capacity make sense for older adults.

4. Section II (Identifying Community Issues) – Are the issues identified consistent with the intent and language of the MHSA? Have we missed any major issues? What specific issues would you add (for your age group)?

Children and Youth

Issues

- Many counties are not offering minor consent service at all: address this.
- Parents should not have to give up custody of their children to get help; there needs to be a funding source for out of home placement of children without Medi-Cal.
- Illness creates turmoil in families: parents with other kids at home are often not able to care for them. They need respite care for children as a step-down from acute care and child care support.
- It is hard to get services for children and youth with SED and substance abuse in both systems.
- Address multiple placements in foster care.
- Untreated mental illness can develop into domestic violence.
- L.A. survey showed that a large proportion of children diagnosed with depression or other SMI had experienced or witnessed violence. Data lead to conclusions about domestic violence and mental health.
- There is a huge underserved population who have conduct disorder whose parents need a one-stop shop with integrated service, similar to System of Care.
- Partner with the funding available from Proposition 10, Children and Families Commissions. How can we leverage those funds for the young ones who are not yet diagnosed?
- Include all things mentioned for adults and older adults, including homelessness as result of SMI, sibling and other issues.
- Include cognitive delays.
- Establish a community center for children with mental health issues to hang out; this would be a place to provide treatment without mental health stigma and to include the education. More families and children would be open to this arrangement. Promote it with flyers, newspapers, health fairs.
- Advertise in taxis to help children.

Lack of Emphasis on Children

- Why is the language so similar for all age groups?
  - **DMH Response:** DMH attempted to put everything in one document and to get specific about system capacity. I hear suggestions of making separate sections in the document rather than trying to blend all into all the age groups.
- Separate the age groups into different sections so we are truly addressing children's needs, not getting stuck on politics.
- When the document was written, were there experts in children's services as part of the team?
  - **DMH Response:** Yes, but obviously not enough.

- Page 10-11: identify prevalence data and redo that table: it does not address children.

Language
- Replace "normal" school environment with "mainstream" or other language.
- Use language from Proposition 10 document *Birth to 5* about school environment.
- Currently, children need to be labeled with SED to be eligible for an IEP to qualify for services. Modify language so that MHSA is not limited to children with IEPs in the school system.
- Regarding the language of DMH priority community issues (Direction box, page 10): counties can develop a program not readily identified as long as they justify their choice.

Education and Training
- Education is needed for parents, teachers, educators and law enforcement.
- Kids experience stress just getting up and going to school; while we can not fix it, we can support them.

System of Care
- System of Care principles are required by this legislation but are not reflected in the guidelines.
- Add that the System of Care is driven by data; we have data demonstrating that it works.

Transition Age Youth

Lack of Emphasis on Transitional Age Youth
- Rename this section so that it better reflects the experience of transition age youth. There is a lack of community services and support for transition age youth. Is the issue identifying community issues or identifying the lack of services resulting in untreated mental illness?
- Be more explicit with the identification of community issues specific to transition age youth who do not have access to support services. Assess the impact on transition age youth who do not have normal developmental opportunities.
- In the Section II Community Issues Direction box specific to transition age youth: add inability to be successful in school, inability to be in the least restrictive settings and inability to manage financial independence. Try to address understanding barriers to living independently for transition age youth.
- Ask transition age youth to identify what education, training and support they need.

System of Care
- What are the ways that youth are supported in the transition from foster care to adulthood? All systems need to be working together in the transition.
- List conditions that are barriers to the coordination of care and the factors that create barriers.

- Add the importance of partnerships and collaboration between law enforcement and social services, e.g. Crisis intervention Team Training (CIT).
- Add the need for a seamless system for services and training for transition age youth.
- Add more narrative to clarify the deterioration that results from longer periods of institutionalization/incarceration.

General Issues

- Add gender issues to the community issues for transition age youth.
- Add the difficulty of dealing with after effects of traumatic relationship experiences, e.g. trauma from family violence, dating and relationship issues, sexual assault and rape.
- Add supportive housing services, timely education and resources for transitional age youth.
- Page 11, Response: add self-help, youth and client-run services.
- Expand evidence-based programs such as home visits by nurses for transition age youth.

Adults

- Counties will be able to read much of this as permitted, not directed. DMH should be more directive about this.
- Is there a place in the document that allows the family members to be part of the 24/7-response team?
- Advance directives should be at the discretion of adult clients.
- DMH needs a middle road approach to have a much more prescriptive set of requirements, as most of the work is going to be the bird-dogging of the counties afterward. DMH should require that counties work with specific populations and obtain information from clients about program success. If DMH then assesses performance based on that information, it could withhold Year 2 funding if the counties do not meet the outcomes.
- Give general parameters to allow communities the opportunity to see what the outcomes of untreated mental illnesses are.
- Need more early interventions.

Older Adults

- Are we a “community problem”? The language and terminology feels like we are not being looked to as individuals.
- Change language to emphasize wellness and recovery values.
- Page 10: what does this mean: “*Which clients and family members needs and concerns are not presently supplied by this county*”?
- Address stigma, local community issues and demographics of community.
- Frame issues from consumer perspective.

- Differentiate emphasis between adults and older adults throughout document.
- Reflect Olmstead with emphasis on in-home and community-based services.
- Integrate older adult system of care framework.
- Include co-occurring disorders.
- Need to emphasize older-adult specific outreach, which is not typically seen in the existing system.
- How you define community: reflect cultures within community.

5. Section III (Assessing Unmet Need): Is this section understandable? Have we given enough direction so that counties will have some consistency in whom they consider underserved and inappropriately served? If not, what else is needed?

<u>Children and Youth</u>

Data Sources and Needs

- Add number of children, and those being placed out of county.
- Add children with developmental delays along with children with hearing and visual impairments.
- When the vast majority of children are in schools, why are we looking elsewhere for data?
- County foster care systems should be required to collect data on the numbers of children waiting placement and the specific reasons they are waiting: e.g., no appropriate foster care or group home placements available, etc.
- How can small counties take prevalence data minus the number of persons served? It sounds "so easy." Take caution: if it is so easy, the data may not be reliable (lesson learned in IEBP process in system of care).
- Page 12: Counties should provide community data about care outside of county services and programs, by reaching out and including mental health need and care data from non-profit, community clinics and other private services and programs.

Lack of Emphasis on Children and Youth

- Why are children and youth with SMI or SED not included, but transitional age youth are?
- Have examples for children who are underserved: i.e., children who have been assessed, but are not receiving ongoing treatment.
- Training needs to be done in the public sector about the process. Need awareness that mental illness can happen in children.

General Issues

- If a child is turned away from services, there should be a clear appeal process.
- Add language that will improve access for early intervention to prevent mental illness. For example, privately insured, middle income children functioning educationally in high school do not have coverage for their mental health needs.

Children who are pre-suicidal cannot get help to prevent those behaviors until they make a serious attempt.
- Use bold paragraph headings to clarify topics.
- Partner with public health to identify underserved and unserved children.
- MHSA is for those who have no funding source, not those with Medi-Cal or EPSDT
- Regarding "at risk of" language: Add "and in need of mental health services."
- Does MHSA provide for under-insured as well as uninsured?
- Why not contract with Adults' System of Care and have a plan to have adult consumers help uninsured youth?
- Why 200% of federal poverty level (FPL)? If a family has income at 201% FPL, they do not have access, although they are underserved.
    - **DMH Response:** The poverty level is typically used nationally as the population most likely to access public mental health services. It is just for planning purposes; it does not mean counties cannot serve families with higher incomes.

Transition Age Youth

- Page 16: revise the Specific Populations/Transitional Youth to add *who have been diagnosed with serious emotional illness*. Add to the categories: at risk of homelessness and involuntary hospitalization.
- Transition Age Youth diagnosed with SED, unserved or underserved homeless or at risk of being released from, involved or at risk of becoming involved with the juvenile justice systems.
- Ensure that the definition of transitional age youth is broad enough to include youth in the foster care system e.g.16 years old
- Encourage counties to develop age appropriate independent living situations for transitional age youth.

Adults

Unserved/Underserved

- MHSA dictates a new meaning to underserved: those whose services do not provide every opportunity to participate and move forward in a process of wellness, recovery, resilience.
- Page 11: look at prevalence rating and subtract who you are serving, those become the unserved.
- Page 12: so many are medicated and many do not need it.
- Page 12: someone who is living in an institution needs a different set of housing and support options, such as a 24 hour social model.
- Page 13: there are many hidden homeless who are not served. Sacramento County counted 600 homeless and advocates said we should multiply it by a factor of 10.
- Page 13 chart: add people who are underserved and inappropriately served.
- Count people who are being made ill by their treatment.
- People in board and care facilities could be more independent if properly treated.

- Count clients whose services do not adequately address “at risk” situations.
- Add “Outreach workers must make brief one-on-one contact with clients from each unserved or inappropriately served group in settings specific to each population, for example:
  - Visit reservations and community centers to reach Native Americans;
  - Visit needle exchange sites, drop-in centers, outdoor areas with visible presence of illicit drug activity, and drug treatment facilities to reach dually diagnosed youth and adults;
  - Visit IMDs and nursing homes to reach institutionalized adults;
  - Visit homeless shelters, outdoor encampments and drop-in centers to reach homeless adults”.
- Add “Outreach workers must keep a written record of each contact with an unserved or inappropriately served person to establish numbers and must collect brief, anonymous needs assessment data from contacts who agree to participate.”
- Add “DMH will provide outreach worker training and needs assessment services in order to determine numbers and needs” Note: consider contacting San Francisco’s Institute for Community Health Outreach at www.altrue.net/site/ichoca/ for copies of training manuals, outreach logs and needs assessment surveys that can be used as a model for a statewide reference or template.

Assessment Criteria

- Use suicide rates.
- Include sexual orientation in tables and charts.
- Add assessment of services and supports that help clients achieve independence: vocational services, self-help groups, etc. Ask for not only what is current, but what is missing and should be addressed by MHSA.
- Homeless surveys are useful tools.

Cultural Competence

- Include data on general disparities in service levels among underserved groups.
- Page 13: it is important to put a ratio of current staff, for ethnicity, race, gender, etc. on all exhibits. There needs to be underrepresented ethnic groups listed on the exhibits.
- Cultural and racial disparities are real and make cultural competence trainings so important. For example, the jail population is disproportionately African American.
- In order to ensure accuracy in estimating the numbers and identifying the needs of underserved or inappropriately served clients, each county must hire or recruit volunteer community health outreach workers. These outreach workers must be fluent or conversant in the county’s predominant non-English languages and/or must have lived experience and/or some expertise on each underserved or inappropriately served population.

Co-Occurring Disorders

- There is a lack of emphasis of co-occurring disorders. Within the adult mental health system, it is expected that the majority of the population has co-occurring disorders.

- Page 11: Co-occurring disorders: address treatment needs, and assessment should include HIV, substance abuse, etc. There are many county plans within areas serving people with co-occurring diagnoses or issues, such as the homeless plan, HIV, etc.

General Issues

- Use "shall include but not be limited" language in the requirements document to emphasize how many other possibilities should be addressed: All sorts of services should be prescribed and counties would be embarrassed to see how many they are not providing.
- There are no quantifiable steps to move from providing nothing to providing the AB 2034 Cadillac model.
- Does "inappropriate" mean inappropriately using the mental health system (i.e., should be in primary health care) or getting the wrong services?
- Everything needs to be grassroots; we need to help each other. This must be transformation and revolution.
- Mission statement should include the concepts of compassion and help
- It is not clear where to use the tools in Appendices C & D.
- The document is not user friendly: it should be written at the level of those who will be using it.

Older Adults

- The language does not incorporate wellness and recovery.
- Insert Planning Council's Cultural Competence Long Term Plan language
- How do you hold county accountable?
- Some data areas in the section do not lend themselves to scientific analysis, such as underserved "family members."
- What is the definition of family?
- Create two sections, one that is available quantitative data and one that is more qualitative.
- Make the best estimates of unmet need.
- This section may require the counties' cultural competence plans to be updated.
- This will require a hard look at demographics.
- Must include gender, disability, and other factors for older adults.
- In addition to unserved and underserved, counties should be required to include categories of badly served, those needing services that are not available in the system, inadequately served.
- Older adults often receive lots of services, but they are not integrated or coordinated.
- Big difference between prevalence data and unmet and invisible populations.
- Need more direction for counties: make requirements more clear, with more specific instructions.
- How can DMH make sure funding will go to older adults? Will there be a formula or requirement for certain percentage of funds based on population?

6. **Section IV (Identifying Focal Populations): For each age group – Have we identified the correct initial focal populations consistent with the MHSA? Are they too prescriptive (not allowing enough county flexibility) or not prescriptive enough? What focal populations would you add or exclude?**

Children and Youth

SED Label

- Children with SED label often are not diagnosed more specifically and will not receive treatment. If these children have a real illness, it needs to be noted and treated.
- Language should be modified to read "Children/youth and families – Have been diagnosed with SED, unserved or underserved or inappropriately served, homeless or at risk of becoming homeless, in juvenile justice system, youth placed out of county, institutionalized or being discharged, at risk of out-of-home placement."
- SED is very restrictive: it might exclude those who are not SED, but need services
  - **DMH Response:** The terminology about SED does not seem restrictive. The SED criteria are less strict that the Emotionally Disturbed criteria used by the education system.

General Issues

- The supplantation language is confusing: some children are entitled, but not enrolled; some enrolled, but not entitled. Will the plan address entitled vs. enrolled?
- In the chart on Pages 17 and 18, regarding numbers to be enrolled, add a column on ethnicity.
- Page 16, second bullet: the definition is perhaps too specific or restrictive and not inclusive enough.
- Add services that are not covered under Medi-Cal and other funding sources. Be careful about how we word so as not to exclude, for example, Kaiser children who come to us due to being under-insured.
- Do the focal populations chosen have to match the community issues identified?
  - **DMH Response:** If we talk about reducing the number of children in juvenile justice system, the basic idea is to have an impact on the population that you identify as one you want to focus on.
- Why are so many populations left out, such as social service population, juvenile justice, children on Medi-Cal?
- Page 16: define DMH priorities.
  - **DMH Response:** DMH tried to balance between being too prescriptive and being so flexible as to not tell a statewide story. We need to be able to point to what has happened as result of the Act. The public will want to see the "story" – otherwise they may vote for the Initiative that is now trying to repeal MHSA.
- Counties will define unserved and underserved their own way. Are there guidelines or criteria to give counties some direction?

    - **DMH Response:** DMH allows counties to struggle with the definition and expects to see creativity as counties come up with their own identities and definition.
- Change "out-of-home placement" to "more restrictive placement."
- Set aside funding to revamp therapy so that children have better experiences with the profession than many of us have had, feeling that our spirits have been broken. Mental health help should include fun and entertainment, especially for children, so they feel motivated to get help.

Transition Age Youth

- Page16: revise the Specific Populations/Transitional Youth to add *who have been diagnosed with serious emotional illness*. Add to the categories: at risk of homelessness and involuntary hospitalization.
- Transition Age Youth diagnosed with SED, unserved or underserved homeless or at risk of being released from, involved or at risk of becoming involved with the juvenile justice systems.
- Ensure that the definition of transitional age youth is broad enough to include youth in the foster care system e.g.16 years old.
- Encourage counties to develop age appropriate independent living situations for transitional age youth.

Adults

Language of Focal Populations and Mental Health

- Seriously mentally ill (SMI) is not wellness language and it is too prescriptive. Open MHSA up to all people seeking help.
- Change from “Adults with SMI” to “Adults diagnosed with SMI.”
- Change from “SMI” to people who are experiencing mental health issues”; however, this still begs the question of standards of who gets served.
- California and MHSA are at the forefront of innovation. The words we use in the document are even more important because people in other states will also look at this and follow our lead. SMI needs to be changed, to be more client-oriented.
- Use SMI: if we expand the definition too much, then MHSA will have to serve everyone with any mental health issue and it will cost too much.
- SMI is a stigmatizing term.
- What term do you use if you do not use SMI?
- Using wellness language, we should knock off the labels. They are barriers
- Our agency does not use SMI or seriously and persistently mentally ill (SPMI): we use “people who have been labeled with a mental illness.”
- There are so many demands for this money that it may be important to strike a balance, and to find a way to protect the people in most need of care and educate the community about the stigma issues. If we open MHSA up, all the social service systems that are failing will try to obtain funding here.
- Violence is implicit with use of the word “targeted” to describe populations.

24/7 Support

- Personal services coordinator – have attendants who are employed by the clients.
- Personal services coordinator, expected to respond 24/7 is not feasible for mental health workers. Are we talking about a team? If you use the CASRA model, you have a personal relationship with your personal services coordinator. Say that explicitly.
- 24/7 needs boundaries.
- Not every one needs 24/7.
    - **DMH Response:** If someone is enrolled in MHSA level services, with lower case loads, then they might need those services.
- If you are too specific, if you say everyone needs a personal service coordinators, you are denying flexibility.

Client-Centered Focus

- Page 15: include client empowerment, quality of life.
- Page 15: people who get minimal services. Add personal empowerment.

General Issues

- This act should not be used to fund care for children and youth in the juvenile justice who are not being cared for The document does not address people in institutions who are not guilty by reason of insanity, or incompetent to stand trial: those are most of the people in state hospitals.
- Get away from typecasting people and focus on the types of care they need. Some people need daily interventions some do not need that because they have natural support systems .
- Financing should be looked at simultaneously. Need to look at Section V – some communities have no choices. Section IV has to be complemented by Section V
- Counties should be required to assess their self-help groups.
- There may be an appropriate place for enrolled placement, but enrollment flies in the face of self-help centers. If you have enrollee language, you will destroy self-help systems.
- Page 16: There is no reference to outreach. That specific word needs to be in there
- Underserved will be harder to determine.
- Page 15, third bullet (of “Direction”): “…and describe what strategies it will use to *significantly* reduce those disparities in each focal population.” Add the word “significantly.” Incremental reductions of 1% or 2% would meet the requirement as currently stated. Each county will presumably define what “significant” means for that county.
- Page 16, third bullet: after the word “institutionalization” add: “or acute services.” We need to get services to people before they are institutionalized and/or require acute care.

Older Adults

- Who will define the enrolled population? Where should counties start?
- How can Axis 1 definition be incorporated?
- SMI – ICD-9 codes definition: what is not in this definition?
- Do not use stigmatizing language?
- Avoid “at risk of.”
- Measure risk, not a stand alone qualifier on Page 16.
- Late onset of primary diagnosis needs to be acknowledged.

7. Other issues related to Sections I-IV?

Children and Youth

- Look at reducing recidivism in the juvenile justice system.
- Address how to improve school attendance.
- Direct attention to the fact that overrepresentation of Latino, Southeast Asian, and African American youth in Juvenile Hall is related to lack of access to appropriate mental health service in many counties.
- Need a school-based provider/screener who parents and teaches. They often provide after-school programs, treatment, recreation and supportive socialization, medical services; many clients in these groups tend to be ethnic.

Transition Age Youth

Specific Program Models

- Family Bridges for individuals with a mental health diagnosis who are first time offenders.
- Family Connections.
- Daniel’s Place at Step Up on Second in Santa Monica.
- Transitional Age Young Adults (TAYA) Program/Stanislaus County. This program is located in the Wellness Recovery Center. (209) 558-4081.
- Santa Monica Families First funds a program called Visions, serving youth 18-21.
- First Place is a tri-county program serving youth of Alameda, Contra Costa and San Francisco.
- The ACT Program in San Bernardino County.
- The Guardian Scholarship Program in Orange County.
- The Yes Program in San Diego County.

General Issues

- In Section I, be more specific about outreach to youth and how youth are involved in the planning process. Work with Child Welfare Services and the Juvenile Justice System to reach transition age youth.
- Provide recommendations and guidelines to ensure that youth are involved in the planning. Provide outreach to youth in non-traditional ways. Provide a comfortable setting and training to orient youth to the planning process. Only the youth know the answers to where the dollars should go.

- Page 10: add training for foster parents.
- Counties could post the CCS guidelines on their website to increase local involvement in the planning process.
- Transition age youth participants are under-represented on local planning councils and meet barriers when applying for those positions.
- Are there going to be ongoing modifications of the guidelines based on experience?

Adults

- Enrollment is not innovative.
- Part of the notion of client vision is client-centered and client-controlled. This is all top down. Cannot be evidence-based practice and innovative at the same time. DMH needs to back off and let the counties be innovative. Ask the counties how they can show how they can make change.
- You need to look at why you want to help people. If you do not know this, you may hurt people.
- How do we know cultural competence will be embedded? We will have to do that here. When we come back on the 23rd, we need to pay attention to this.

Older Adults

- Need to include more examples of peer support, client-run, self-help throughout the document.
- Allow more time to plan thoroughly.
- Do not forget current problems and current clients as we create new systems.
- Allocation methodology should support thoroughness of planning.
- Add services for Native Americans.

8. Does the format make sense – moving from articulating goals, identifying issues, assessing unmet needs, identifying populations to be served and identifying service strategies to be used?

Children and Youth

Technical Concerns/Requests to DMH

- Is there any way to bring the logic model discussion to set the tone for the document?
- Though it may limit service, it is good that DMH wants us to come up with ideas. Can the state put out a short paper to give county direction, for example, start small, start focused? This would help counties not become overly involved, lose the focus and lose funding. It could be something to hand to Supervisors to help explain and illustrate the requirements.

- The document should mandate direction regarding other county agencies that should be involved (e.g., foster care, juvenile justice). It is not just CMHS' responsibility to provide data, it is a shared responsibility.
- MHSA calls for funding of Children's System of Care (CSOC): if it is not restored, DMH is open to lawsuits; if it is restored and counties have access, how do we use this document in conjunction with CSOC? Make the document more consistent with CSOC.
- Put family partnership as mandate in this MHSA planning document.

Training

- Capacity for system to expand is constrained by the readiness of the workforce. DMH has chosen to move with this part: Training specific to case manager and other staff training must be addressed.
- Counties lacking the capacity to train about system transformation can partner with organizations such as First 5.
- The plan should allow funding for education and training at small level, easing into it rather than waiting 3 years.

Innovation

- System transformation: Designate 55% of the first round funding for projects like family partnerships, rather than just the enrollee-based method.
- Is there a way to prioritize community-based providers as access points for innovation-based treatment and Programs?

General Issues

- The requirements should be to scale, so small counties do not need as large a response as a larger county.
- Respite needs to be provided.
- Transportation is a huge issue.
- Cultural competence is not just about ethnicity.

<u>Transition Age Youth</u>

- The format for the document makes sense if counties have the time to follow the guidelines and complete the plan.
- Need translation of the information so that it is easily understandable. The document assumes that the reader knows a lot about the system which is not the case with the transitional age youth.
- The appendices are helpful as a resource guide. They must be evaluated to ensure they are usable and understandable to stakeholders.
- Consider reordering the sections and moving Section IV, *Identifying Focal Populations for enrolled Member Services* to follow Section I - *Description of the County Community Public Planning Process.*

Adults and Older Adults Groups did not answer this question.